STATE OF DELAWARE

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH
AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

In compliance with Federal Regulations (42 U.S.C. 4582 and 21 U.S.C. 1175) and the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (45 C.F.R. Pts. 160 and 164)

Client Name: _____**DOB:** _____
SS#: _____

I, the undersigned, hereby authorize the **Eligibility & Enrollment Unit** to disclose to the following entities:

- **Brandywine Counseling, Inc.**
- **Brandywine Hills** ***(RHD)***
- **Connections CSP.** ***(CCCP/Meadows Res./Blackbird Group Home)***
- **Delaware Psychiatric Center**
- **Division of Vocational Rehabilitation**
- **Fellowship Health Resources** (CCCP,***Georgetown Group Home/ Hope House Group Home/ Taton Group Home)***
- **Gateway Foundation**
- **Gaudenzia**
- **Horizon House** ***(CCCP/ Bennett House/ Wilson House/ Old Balt. Pike)***
- **Limen House**
- **Now Group Home** ***(RHD)***
- **Psychotherapeutic Services, Inc.** ***(CCCP, Felton Group Home)***
- **Other:** _____

the following information: **the Eligibility & Enrollment Application Packet, ASI, Assessment Summary, ASAM Summary, Consumer Reporting Forms (pages 1 & 2), Eligibility & Enrollment Summary Sheet and the S.E.T. Service Authorization Form.**

The purpose or need for this disclosure is to coordinate behavioral health care treatment.

I understand that my records are protected under federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 and 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it. I understand that my private health information, once disclosed to others, may be redisclosed to individuals or organizations not subject to HIPAA and may no longer be protected by HIPAA. I understand that generally DSAMH may not condition my treatment on whether I sign an authorization form, but that in certain limited circumstances I may be denied treatment if I do not sign an authorization form.
This consent extends from this date until 60 days post discharge from DSAMH/Contracted services.

Signed_____ **Date** _____

_____
(Relationship if signed by other than client)